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NORTHUMBERLAND & DURHAM  
MEDICAL SOCIETY.

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MARCH 11, AND APRIL 8, 1880.

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# NORTHUMBERLAND AND DURHAM MEDICAL SOCIETY.

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THE sixth monthly meeting was held on Thursday, March 11th, in the Library of the Newcastle-on-Tyne Infirmary, the President (Dr. Armstrong) in the chair.

The following gentleman was proposed as a member of the Society :—

John Service, L.R.C.S. and P. (Edin.), West Boldon.

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## PREVALENT DISEASES OF THE DISTRICT.

Mr. HENRY E. ARMSTRONG presented the following

*Return of Admissions to and Deaths at the Newcastle Fever Hospital, during the months of January and February, 1880 :—*

				Admitted.		Died.	
				Jan.	Feb.		
Scarlet Fever	...	...	...	2	0	...	0
Measles	...	...	...	0	1	...	0
				—2	—1		—0

All the cases were mild.

Dr. BARKUS remarked upon the number of cases of measles which had occurred recently in the Gateshead district; but the cases did not present any feature of interest.

Mr. GAMMAGE said there had been many cases of late in Sunderland, mostly of a mild type, but no peculiar feature had been noticed.

The PRESIDENT said he had recently met with many severe cases of whooping cough, but the characteristic “kink” was absent in most of the cases. He would like to know if any gentleman had met with such cases, for, as a rule, the so-called “kink” was unmistakeable.

Dr. MUNRO said he had recently had a case of scarlet fever under his care, which presented some points of considerable interest. The fever was of medium severity—temperature 102° F. to 103° F.—which ran its course naturally and subsided in about a week, when the temperature fell for a day or two, and then there was albumen in the urine for three days. The temperature rose again, then fell, and the albumen quite disappeared, and the child was apparently convalescent; but in the course of three or four

days the temperature rose again to  $102\frac{1}{2}^{\circ}$ , and kept from  $101^{\circ}$  to  $102^{\circ}$  for several days, and then rose again, and remained so for a week or ten days, and then subsided again, so that following the scarlet fever, apparently an attack of continued fever occurred, either simple, or rather of an intermittent type. There was no diarrhoea, nor albumen, no evidence of any congestion of any organ or gland, or any abscess or suppuration to account for the increased temperature, and the child was bright, but irritable and naturally highly nervous. The child is now quite well.

Dr. MACLAGAN asked if scarlatina was prevalent in the Shotley district? he had heard of cases in that neighbourhood. He also had seen cases of pertussis without the "hoop."

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### PATHOLOGICAL TRAY.

Dr. OLIVER showed specimens from a case of multiple tumours, and said: R. C., aged fifty years, a miner, was admitted into the Infirmary, under my care, about nine weeks ago, complaining of great debility and hæmorrhage from the surface of a tumour in his left axilla. He was a man of average size and build, and, with the exception of having suffered from typhus fever in childhood, had enjoyed good health until about three years ago. He was extremely cachetic, and had all the appearances of a man suffering from malignant disease. About six years ago, patient met with an accident which smashed the metacarpal bone of his right index finger. This was followed by erysipelas, which extended up the arm, involving the lymphatics. After this had existed for some time, the glands above the right clavicle became enlarged and slightly painful—and have remained permanently enlarged since then—the pain during this period having disappeared. About six months ago, patient noticed a lump under his left arm, which was hard but not painful. This lump grew in size; and as patient used to lie on his left side while working in the pit, the tumour began to ulcerate on the surface, probably as the result of friction. Almost contemporaneous with the appearance of the tumour in the left axilla, nodules of various sizes began to spring up in other parts of the body. In size varying from a small bean to a hen's egg, they were found distributed over the anterior and posterior aspects of the trunk, apparently obeying no definite law in their distribution beyond the fact of being for the most part superficial. About fifty tumours were counted on his chest and abdomen, and eighteen on the back. The superficial glands were all enlarged.

On examining the chest, beyond a little deficiency in the respiratory sounds, the lungs seemed healthy. The heart was

healthy; no cerebral symptoms; the spleen was noticed to be somewhat enlarged. On microscopical examination the blood was found to exhibit the character of that taken from a case of leucocythemia, viz., a large increase of white corpuscles, diminution in size of the red blood cells, and an absence of the tendency to form rouleaux. Patient was ordered milk, beef tea, custard pudding, with sherry wine. The medicinal part of the treatment comprised syrup of the iodide of iron, syrup of the phosphates, and Faston's syrup; arsenic was also employed. The debility however increased, a debility quite unaccounted for by either hæmorrhage from the tumour or the state of any organ, unless it be from the altered character of the blood and a little pneumonia having developed, it precipitated the fatal termination of his illness, and enabled me to lay before you some of the points of interest in his case.

*Post-mortem Examination.*—The brain, lungs, liver, were found to contain new growths, which could with perfect ease be enucleated; the spleen was in the condition in which you now see it; all the glands were enlarged. One of the peculiarities in this case was the absence of all cerebral symptoms, and even of optic neuritis, which, according to Dr. Gowers, is never absent in intracranial tumour. Tumours, sarcomata.

Dr. DRUMMOND said he thought the case just related to them by Dr. Oliver, one of great interest, both from a clinical and a morbid anatomy point of view. He had seen the case in the wards through Dr. Oliver's kindness, and had made the *post-mortem* examination. It was a matter of regret that the brain had not been preserved for the Society, but unfortunately the anxiety to make out accurately the position of the morbid growths, rendered destruction of the brain substance unavoidable. The fact that a growth of considerable size could occupy the corpus striatum without giving rise to paralysis, was a matter of great interest. It was also important to note the absence of the neuritis. He (Dr. Drummond) had examined the eyes and failed to discover any ophthalmic change, nor at the *post-mortem* did the discs look unhealthy.

Dr. BRAMWELL said he had met with several cases of intracranial tumour where optic neuritis was not a symptom. He thought it had been laid down by Charcot and others that the corpus striatum might be destroyed without paralysis so long as the fibres in the internal capsule were uninjured.

Dr. PHILIPSON said the case described by Dr. Oliver reminded him of one something similar in nature which had come under his care. The spleen was the seat of several tumours, and the superficial glands in the body were very much enlarged.

Dr. OLIVER replied.

Dr. ARNISON showed—1. A specimen of cancer of lower end of femur, occurring in a woman of 54 years; previously healthy. It was of two years' duration, and on admission, the case presented simply the appearance of advanced "white swelling." After amputation, the lower end of the bone was found to be infiltrated with cancerous material. Two microscopic sections were shown, prepared by Mr. Squance, one of the senior students. 2. Right tibia of a boy of 15, in which rapid necrosis had followed a slight injury. At first it was thought possible that the limb might be saved, but the inflammation extended to the knee joint, with suppuration in the joint, and as the boy's health was giving away, amputation was deemed necessary. 3. An ovarian cyst, removed on the 29th ult., from a woman of 25. The diagnosis, which was confirmed at the operation, was one large cyst below, a smaller cyst above, and some solid matter. After the removal of the ovary, which presented no features of special interest or difficulty, the opposite (right) ovary was found to be expanded into a cyst as large as a small orange, and was, therefore, removed; it burst during removal, and was not kept.\*

Dr. MACLACHLAN showed a specimen of twins which survived birth, having been but seventeen weeks in utero, and said the children certainly lived and continued to breathe for nearly an hour after birth. The case was of interest from a physiological as well as a medicolegal point of view.

He also exhibited a photograph of a case of elephantiasis of the face, which he had obtained when in Iceland last year, where the disease is very common.

Dr. BRADLEY asked if Dr. MacLachlan had registered the birth of these children. He thought it was common enough for respiration to continue for some time after birth after the twenty-first week of intra-utero existence; but at seventeen weeks it was very unusual.

Dr. MACLACHLAN said he had not registered the births, though it was a question whether it should have been done or not.

Dr. HEATH showed—1. An ovarian tumour (*exhibited at a former meeting*), and said that his chief object in doing so was to again point out to the Society the presence, along with the main cyst, of a considerable semi-solid mass made up of those smaller cysts, whose presence, detected during life, afforded such valuable assistance in forming an opinion of the nature of any abdominal tumour. This was the fourth ovarian tumour he had shown at the Society in a few months, and each had pre-

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\* The ovaritomy case is nearly well; and the two amputations promise a favourable recovery. Both pedicles were tied with silk ligatures, and left in the belly

sented the secondary cysts. The main sac in this case was so thin, that it was unable to bear the weight of contained fluid after the support of the abdominal wall had been removed by incision, but burst, and thus allowed some of the contents to pass into the belly. The patient, however, made a rapid recovery, and was, in fact, fit to leave the Hospital on the tenth day after the operation.

Dr. Heath said : The ovarian tumour which I show this evening possesses several interesting features. It consists of one large and several smaller cysts. The wall of the large cyst is greatly thickened and shows externally, and chiefly on what was the anterior surface marks of extensive and close adhesions. The interior is very vascular, and presents at one point some thin flakes of bone, and at others yellowish matter adhering to the cyst resembling caseous matter. The smaller cysts contain the usual gelatinous contents, and are placed towards the circumference of the larger bag. The position of the tumour previous to removal was somewhat peculiar, it was placed higher than usual, and projected forwards so as to make the belly more prominent than the size of the tumour accounted for. There was a considerable area of clear stroke-sound on either side and behind the tumour. Thus there was an exaggeration of the ordinary signs of ovarian disease. The patient had been several times tapped previous to her admission into the Infirmary ; the contents of the sac upon the last occasion being pus. After admission, four pints of pus were drawn off from the cyst ; after tapping, the temperature, which previously had ranged from  $100^{\circ}$  to  $102^{\circ}$ , fell to the normal point, and extensive adhesions were found at the operation, the greater part of which readily gave way to the hand. Some portions of omentum, which were very closely adherent to the sac, were much thickened and altered, these were cut off, and bleeding vessels tied with catgut. The adhesions were chiefly on the upper and front surface of the tumour, and were, no doubt, the cause of its peculiar position.

2. Conical bullet removed from *thigh*. The bullet had been fired from below, and had run up the thigh for several inches, first between skin and fascia ; afterwards the fascia had been penetrated and a bed made for the projectile between the fascia and muscles of thigh. The bullet was removed by the finger, the external wound being first enlarged.

3. Lower end of femur removed by amputation and sequestrum from medullary canal of the same bone showing results of osteomyelitis.

At the last meeting of the Society, Sir, I showed a tibia and knee joint presenting the results of acute osteo-myelitis. I now present to the Society these preparations, exhibiting the results of the same disease in a more chronic form in the femur. It will be observed that the lower end of the femur is enlarged, and presents

three openings, through two of which a probe has been passed ; one of these is on the inner aspect of the bone towards the popliteal surface, the other is on the front of the bone. The probe now lies in a sinus not much wider than the probe ; a year ago this sinus was a large cavity, into which the finger could be passed with ease, great part of the cancellous structure having been destroyed by suppuration opening up this cavity, freely clearing it out, washing out with chloride of zinc solution, and afterwards dressing antiseptically resulted in a great improvement in the boy's condition, and brought about the contraction of the cavity as now shown. In consequence, however, of renewed constitutional disturbance, and the occurrence of fresh suppuration, and also the unwillingness of the patient to submit to the extension and other treatment necessary to bring about a cure and save the limb, it was determined to amputate at such a point as would intercept the source of the new attack of suppuration. In sawing through the bone, the sequestrum exhibited dropped out of the dilated medullary cavity of the bone.

Probably the diseased action commenced in the shaft, and gave rise to the internal necrosis, the affection of the cancellous structure being secondary, and that of the knee-joint tertiary. Taken together these morbid specimens are interesting illustrations of the effect of inflammatory action of similar character in the three different sites, viz., the medullary cavity of shaft, the cancellous structure of joint end of bone, and the joint itself, where the destruction of cartilage and corrosion of bone surface are seen in more than one stage.

This conical pistol projectile removed from the thigh presents nothing remarkable in itself ; I show it only as a means of drawing attention to what is so often seen in gun-shot wounds, viz., that whilst the track of a projectile exhibits all the signs of inflammation, the body itself lying at the extremity of the track seems to excite little or no action. The bullet was removed by the finger.

(Some of these specimens were exhibited at a former meeting of the Society, but the notes did not arrive in time for the month's Transactions to which they belonged, consequently they are inserted here.)

Mr. MEARS showed an aneurism of the thoracic aorta and loose body in heart, and said : The preparations shown were found in the body of a "subject" in the dissecting-room without obtainable history. The aneurism, situated partly above and partly within the aortic orifice of the diaphragm, was sharply defined, sacculated, oval in form,  $2\frac{1}{2}$  in. long by  $1\frac{1}{2}$  in. broad, very prominent, and projecting anteriorly to the left of the vessel. The walls were

thin, and the cavity was dilated into secondary pouches, which contained laminated clot. The vertebral ligaments and column were quite unaffected. Bursting of the aneurism had probably caused death. Blood was effused into the substance of the diaphragm and round the left kidney, and thence had extended beneath the peritoneum into the pelvis, the floor of which it flooded. The aneurism, therefore, showed characters rarely met with. The remaining portion of the aorta and the other larger vessels appeared to be perfectly sound, and free from atheroma or other changes. In the cavity of the left auricle of the heart of the same subject a small, ovoid, smooth brown body (shown) was found,  $\frac{1}{2}$  in. long by  $\frac{1}{4}$  in. broad, quite free, and showing no signs of pedicle or other attachment. On section, it was seen to consist of an irregular nucleus of hard, calcified material, and a cortical portion of concentric, firm, fibroid laminae. From its appearance and characters it appeared to be a polypoid growth, detached probably through absorption of the pedicle.

The PRESIDENT showed a specimen of placenta and umbilical cord in which the latter had become occluded.

Dr. EMBLETON showed an aneurism of ascending aorta which ruptured into the pericardium, sent to him by Robert Elliot, Esq., M.D., Carlisle. The case occurred in the practice of Dr. Walker, of Carlisle, who gives the following details of it. Wm. Denwood, 49, handloom weaver, died at 4.30 p.m., on the 8th of March inst. Autopsy eleven hours *post-mortem*. The body was well nourished and seemed to be that of a man younger than 49 years. Cadaveric rigidity very marked, in left groin is a hernia. No signs of violence on the body. The pericardium and its contents alone required to be noted. On opening the pericardium it was found quite full of coagulated blood; the heart itself appeared healthy, but the aorta was so capacious as to be capable of containing a medium sized orange, aneurismal dilatation. In the cavity was found a small aperture admitting the passage of an ordinary goose quill, through which the blood had escaped into the pericardium, where it was found so abundantly that the abrupt termination of a life previously of unchallenged reliability was at once explained, the aorta not being capable of transmitting blood to the brain, the heart having suffered considerable compression and thus being greatly hindered in its action.

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#### EXHIBITION OF PATIENTS.

Dr. HUME showed two cases of extroversion of the bladder. The first case was that of a young man, aged 29, who had been for some time in the Infirmary, and had been operated upon. The

method of operation was that practised by Mr. John Wood. Unfortunately the patient, who was of a morose, impracticable temper, inserted his fingers underneath the flaps a few days after the operation, and destroyed all chance of satisfactory union. The exposed bladder surface has nevertheless to some extent been covered in, and what has been done will render the fitting and wearing of an apparatus more easy.

The second case was that of a young child, in whom the breach in the anterior abdominal wall was of much less extent than in the former. The condition was one rather of epispadias than extroverted bladder. The cleft in the penis extended, however, into the bladder; and the case was interesting as showing that the two conditions are only degrees of the same congenital malformation. On account of the age of this patient it was not proposed to operate at present.

Dr. DRUMMOND introduced a young woman, aged 22, who was suffering from hysterical paraplegia. The case had been under observation for about three years. At first the symptoms complained of were those which usually are considered to make up the "symptom picture" of spinal irritation, viz., backache, hyperæsthetic areas, vomiting, inframammary pain, &c., &c. Subsequently, hysterical lameness was developed, resembling hip joint disease. Ten months ago, she was confined to bed with complete motor and sensory paralysis, affecting the lower extremities. At the same time the skin over the dorsal spines and the abdominal walls was very sensitive, the slightest touch giving rise to the complaint of pain. The condition of the limbs was peculiar, the most energetic voluntary effort (?) failed to produce the slightest movement, the insertion of pins caused no inconvenience, nor did extreme thermal irritations excite pain. Tactile impressions alike failed to elicit a response. The whole of the right limb up to the crest of the ilium was affected by this exaggerated sensory impairment, whilst on the left side a line drawn round the thigh at four inches above the patella, was a tolerably well marked line of demarcation between the normal and the impaired sensory condition. The legs were more or less rigid, as in cases of primary sclerosis of the lateral columns. Tendinous reflexes were exaggerated, on the right side especially, the ankle clonus being very noticeable, whilst a sharp tap on the patella tendon caused three or four contractions in rapid succession of the quadriceps muscle. Of vesical or rectal trouble there was none, save for one short period, when retention of urine (hysterical) necessitated the use of the catheter. This soon passed off on the substitution of the nurse for the house surgeon as the manipulator. There was no trophic disturbance of any description, neither bed sores or wasting.

There was no departure from the normal in the electrical condition of the muscles. Latterly, great improvement has taken place in both the phases of the paralysis, *i.e.*, motor and sensory, and this can undoubtedly be ascribed to the use of the strongest Faradic current which could be obtained.

Dr. BRAMWELL said he was very much interested in the case which Dr. Drummond had just exhibited to the Society. There were many features which appeared to point to an organic lesion as the cause of the paralysis. He did not think increase of the tendon reflexes had been often noticed in functional paralysis, though it was true Charcot had observed the condition. Absence of vesical and rectal disturbance simply established the fact that the lumbar enlargement was not seriously affected. The fact that the patient was recovering by the application of a strong interrupted current certainly pointed to a functional origin.

Dr. HEATH said : The patient now shown, a man between forty and fifty years of age, sustained a severe compound fracture of the leg some two years ago. He was in danger, I understand, of losing the leg, but by great care this was avoided. When he became my patient, however, I found the limb, although firmly united, greatly distorted, the deformity having the peculiar characteristics so frequently met with, in varying degrees of intensity, in fractures at the junction of lower and middle third of the leg. At the seat of fracture the bones of the leg were bent at an obtuse angle, whose opening presented inwards ; the heel was drawn up, the sole of the foot was directed obliquely outwards and downwards, and could only with difficulty be placed upon the ground ; he also suffered, more or less, constant pain. Having before had to deal with cases of this description, I suggested to the patient an operation by which the condition of the leg might be ameliorated ; to this he gladly consented. Without taking up time by going into detail, I may say that the operation consisted in sawing and chiselling out a wedge-shaped piece from the tibia at the apex of the obtuse angle, dividing the fibula with chisel, and bringing the plain surfaces of bone thus obtained together, and the leg into a straight line. The limb was placed upon the splint which I have here, and which has already been exhibited to the Society as a convenient apparatus for treating compound fractures of thigh or leg, or excision of knee. The patient made a good recovery, and, as you see, has now a straight leg, though shorter than the other. With a high heel and thick sole to his shoe he will be able to walk fairly well.

(This patient was exhibited at the January meeting, but the notes were too late for insertion in the Transactions of that month.)

## THE DIFFERENTIAL DIAGNOSIS OF CHRONIC BRIGHT'S DISEASE.

By DR. BYROM BRAMWELL.

UNDER the general term Chronic Bright's Disease, at least three distinct affections of the kidney are included. I propose this evening to contrast their several symptoms, and thereby to indicate the mode in which they are to be distinguished during life.

Each of these three affections present distinct pathological characters, and they are usually termed (1) the cirrhotic, (2) the large white, and (3) the amyloid varieties of Chronic Bright's Disease.

I will, with your permission, before passing to the clinical part of the subject, briefly detail their pathological differences.

*Naked Eye Appearances.*—1. *Cirrhotic Kidney.*—To the naked eye, the *cirrhotic* kidney, as the name indicates, is shrivelled and contracted. Its weight is below, sometimes considerably below, the normal. It is of natural colour or abnormally red. Its surface is irregular, marked by little elevations and depressions. The capsule is thickened, and here and there adherent. Cysts, usually of small size, are seen projecting from its surface. On *section*, it is tough and leathery. The cortical or secreting portion of the organ is diminished; in extreme cases, the bases of the cones leading almost to the surface of the organ. The free border of the section is sinuous, showing the elevations and depressions above described; often mottled, with small yellow opaque points, and generally studded with stellate veins.

2. *Large White Form.*—The kidney is increased in size; its weight greater than in health; the colour markedly pale, generally a buff yellow; the surface perfectly smooth; the capsule of normal thickness and less firmly attached than in health. On *section*, the consistency is found to be soft and flabby: the cortical portion is greatly increased in size, it is pale, and presents the same mottled appearance as the surface of the organ: the medulla is usually deeply congested.

3. *The Amyloid or Waxy Form.*—The kidney is generally much enlarged. The weight considerably above the normal. The colour is pale, generally a faint straw yellow; the surface perfectly smooth; the capsule unadherent. On *section* the organ is found to be abnormally tough; the cortex enlarged; the whole organ, both cortex and medulla, markedly anæmic; little glistening points—the degenerated malpighian bodies—are seen on close examination in the cortex. On adding tincture of iodine these little shining spots are stained of a deep brown or even black.

colour. The vasa recta in the pyramidal portion of the organ are stained in a similar manner.

*Microscopical Characters.*—The essential lesion in the *cirrhotic* form is the production of a richly nucleated fibrous tissue between the tubes. The contraction of this fibrous tissue constricts the tubes. Those tubes which are surrounded by the fibrous bands shrink and collapse, though their epithelium is, in the earlier stages at all events, quite healthy. The tubes which are not surrounded by fibrous tissue become dilated. In these dilated tubes the epithelium is generally absent. When present it is altered in character, and is often represented by small round cells. If fluid is poured out into a tube behind the point of constriction, that tube dilates. In this way the cysts, which are constantly seen in this variety, are formed. Many of the tubes become filled with a transparent colloid material. These transparent moulds of the renal tubes are often found in the urine, and are then called hyaline casts. Hyaline casts are generally present in the cirrhotic variety. Important changes are seen in the blood vessels. The middle or muscular coat of the arteries becomes thickened and hypertrophied, as was first pointed out by Dr. George Johnson. In advanced cases the inner coat also becomes thickened, but in a different manner, viz., by the production of a delicate spindle-celled tissue. In extreme cases the lumen of the vessel may become completely obliterated.

This obliterative affection of the inner coat of arteries is of great clinical importance. It occurs, and is highly characteristic of visceral syphilis; it is also seen in the advanced cirrhotic conditions of all organs. The spindle-celled tissue which produces the obliteration of the vessel is rich in blood vessels, and although it shuts off the blood from the portion of the organ supplied by the artery in which it is developed, yet it itself does not undergo degenerative changes.

In the *large white* form there is no increase of the connective tissue, and the vessels are normal. The lesion consists of inflammatory changes of epithelium of the tubes. The cells become swollen and opaque, and finally fatty. The lumen of the tube is completely filled with the degenerated products, which are found in the urine in the form of fatty (and granular) casts. On treating sections of this form of kidney with a solution of perosmic acid, the fatty degeneration of the epithelium is well brought out, for this substance has the property of staining fatty matters black. The tubes from which the epithelium has been shed are seen on sections to be empty.

In pure cases of the *amyloid* variety the fibrous tissue is not increased, the renal epithelium is normal; the parts diseased are the minute arteries. The vessels first affected are the vasa recta,

and the vessels of the malphigian tufts. The malphigian tufts are swollen and entirely fill the malphigian capsules. The degenerative change of the vessels is beautifully seen in microscopical sections which have been treated by methyl aniline. These are the characters of the amyloid variety when met with in a pure and uncomplicated condition—it often happens however that the case is a mixed one—the amyloid kidney being frequently also cirrhotic, and sometimes complicated with epithelial affection.

The large white kidney sometimes becomes contracted.

Such are the leading pathological features of the three chief forms of chronic Bright's Disease. I now pass to the points connected with their etiology and symptoms.

*Etiology.*—The causation of the cirrhotic form is often obscure. Alcohol, gout, lead, and prolonged mental anxiety, possibly through the irritation produced by long continued phosphaturia are the chief causes. The onset is extremely insidious, the course very slow, the affection often lasting for years.

*The Large White Form.*—In a large proportion of cases the large white form is due to a previous acute attack which has become chronic, acute Bright's Disease caused by exposure to cold. In some cases it is secondary to the acute albuminuria of scarlet fever, though in the great majority of cases of scarlet fever, the kidney lesion is quite of another kind, and consists of an inflammatory affection of the glomeruli (*glomerulo nephritis*). Alcohol is a powerful predisposing cause. Some of the worst cases I have met with occurred in the persons of great beer drinkers. Ardent spirits seem rather to produce the cirrhotic variety. In a certain proportion of the cases the causation of the large white kidney is obscure. The onset in many cases of the large white kidney is sudden. The duration is comparatively short (six months to two years).

*The Waxy Form.*—The causes of the amyloid or waxy forms are (1) long-continued suppuration, such as occurs in connection with diseased bone, phthisis, &c. It is also said (2) Syphilis, (3) prolonged exhausting discharges, such as leucorrhœa, and even albuminuri will produce it. On this point I have no personal experience to offer. The onset of the amyloid form is insidious, its course slow, but not nearly so slow nor protracted as in the cirrhotic.

*The Relative Age of Persons Affected.*—The cirrhotic form occurs almost invariably in adults, and is most frequently met with between 40 and 60. The large white form is especially common amongst young subjects; very rarely met with over 60. The amyloid variety may occur at any age, but is most common in the young.

*The Condition of the Urine.*—In the cirrhotic form the amount

of the urine is increased, often very much so (120 ounces per day). The specific gravity is much below the normal 1004—1010; the colour pale; the sediment scanty; the amount of albumen small, in some cases it may be absent for days together, or at particular parts of the day, as the morning. Tube cysts are not numerous, and are difficult to find, because of the great dilution (large quantity) of the urine. The forms met with are the hyaline, both large and small, and the finely granular (not fatty). In many cases of cirrhotic kidney the urine becomes slightly pink after the addition of nitric acid, this is probably due to hepatic complication (hepatic cirrhosis).

In the *large white* form the amount of the urine is generally natural, or smaller than in health; the specific gravity natural, or even increased; the colour natural; the sediment copious; the amount of albumen large; tube casts abundant, the most characteristic being the coarsely granular and fatty.

In the *amyloid* variety the amount of the urine is increased, unless the case is complicated into profuse diarrhoea. The earliest symptom is often the necessity of getting up during the night to micturate. The colour is pale; the specific gravity low; the amount of albumen generally small or moderate (where the urine becomes concentrated by persistent evacuations the amount of albumen is sometimes large); the tube casts chiefly of the hyaline kind.

(In complicated cases, of course, the condition of the urine and other symptom is modified.)

*The Appearance of the Patient.*—Persons suffering from the cirrhotic form are usually sallow and cachectic; their mucous membranes anæmic; but they have not the puffy, swollen, pasty face which is so characteristic of the large white variety. In the amyloid form the face is generally pale, sometimes emaciated, and frequently swollen.

*The Amount of Dropsy.*—Dropsy is generally slight, often entirely absent, in the cirrhotic form. (In this case, as in all the forms of chronic Bright's disease, there may be acute intercurrent attacks, in which the patient may be swollen.) Towards the end of the case dropsy not unfrequently occurs. In the large white form, the dropsy is very constant, and often very great. In the amyloid form there is generally dropsy, but it is not usually excessive. In the earlier periods of the waxy form dropsy is usually absent.

*The associated pathological condition of other organs.*

*The Condition of the Heart.*—In the cirrhotic form, the left ventricle is hypertrophied, and this without any valvular disease. The hypertrophy of the left ventricle is extremely characteristic. Its cause is supposed to be the increased effort which is necessary

to force the blood through the minute arteries, whose channels are narrowed by the tonic contraction of their muscular coat (George Johnson), and by the thickening of their walls (Gull and Sutton).

The arterial tension is markedly increased. The muscular coat of the minute arteries throughout the body is thickened. There is a marked tendency to atheroma.

In the *large white* form the heart is usually somewhat larger than natural, but not characteristically hypertrophied as in the cirrhotic form. The arterial tension is as a rule increased.

In uncomplicated *amyloid* cases the heart is of normal size, or smaller than in health. The arterial tension is not increased.

*The Condition of the Sight and Retina.*—In the cirrhotic form albuminous retinitis is very frequent; indeed, dimness of vision is often one of the first symptoms observed by the patient. In the large white form it is rare. In the amyloid form it seldom if ever occurs. The ophthalmoscopic examination, therefore, is of considerable value in diagnosis.

In the cirrhotic form the liver is sometimes similarly affected (in a state of cirrhosis).

In the amyloid variety, other organs are very generally similarly diseased; the liver and spleen enlarged; the intestinal villi infiltrated, the result being profuse watery diarrhoea.

*Intercurrent Affections and Mode of Death.*—In the *cirrhotic form* uræmia attacks are very common, and often fatal. Cerebral hæmorrhage also not unfrequently occurs, (the result of the thrombotous condition of the vessels, and the hypertrophy of the left ventricle of the heart). Pneumonia, pericarditis, and other acute inflammations, especially of the serous membranes, are common. In the *large white variety* uræmia is much less frequent; erysipelatous inflammation of the oedematous parts; bronchitis; low form of pneumonia; suppurative affections generally; oedema and congestion of the lungs are the chief complications and modes of death.

In the *amyloid* variety, death is usually due to exhaustion, often the result of profuse diarrhoea. The associated pathological conditions, such as phthisis, caries of the spine, &c., are manifested by their peculiar symptoms.

To sum up, the following points are in favour of the different varieties:—

1. *Cirrhotic*: Insidious commencement; long duration; age, adult (generally middle or advanced); history of spirit drinking, lead, gout; urine copious, but low specific gravity, scanty albumen, few casts, chiefly hyaline or finely granular. Hypertrophy of the heart; high arterial tension; albuminous retinitis; apoplectic attacks; uræmia; a similar condition of the liver.

2. *In the large white*: Comparatively rapid onset and course; history of acute attack; age, generally young; great dropsy; urine normal in amount, specific gravity natural, amount of albumen large, casts numerous, the coarsely granular and fatty being most characteristic.

It is often a very difficult and impossible matter to say whether an acute attack has become chronic or not: in such cases obstinate persistence in spite of treatment is of value as a diagnostic.

3. *The amyloid*: Insidious commencement and slow course; history of long continued suppuration or of syphilis; enlargement of liver and spleen; profuse watery diarrhoea; urine increased in amount, specific gravity low, albumen small or moderate; no hypertrophy of the heart; no increased arterial tension; no albumen retinitis; no uræmic attacks.

Dr. PHILIPSON said he must congratulate Dr. Bramwell on the very exhaustive paper with which he had just favoured the Society. There were many new features in Dr. Bramwell's paper as yet scarcely well known amongst the profession. He thought the pure fatty kidney should be mentioned as one of the forms of chronic Bright's Disease.

Dr. ARNISON said he thought the diagrams which Dr. Bramwell had used to illustrate his paper should be published in the Transactions, as far as the finances of the Society would allow. He moved a resolution accordingly.

Dr. MURPHY seconded the motion, which was carried.

Dr. MURPHY then read a paper on "Puerperal Eclampsia," which was published in the last number of the Transactions.

Mr. HAWTHORN moved that an adjourned meeting of the Society be held a month hence, and that the discussion on Dr. Murphy's paper be the first business.

Dr. BRAMWELL seconded the resolution, which was carried.

The PRESIDENT proposed that Mr. Spear, who was recently appointed an inspector under the Local Government Board, should be elected an honorary member of the Northumberland and Durham Medical Society. In doing so, Dr. Armstrong referred in very flattering terms to Mr. Spear's abilities as a medical officer of health.

The resolution, having been seconded by Dr. PHILIPSON, was carried by acclamation.

# NORTHUMBERLAND AND DURHAM MEDICAL SOCIETY.

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AN adjourned meeting of this Society was held in the Library of the Newcastle-on-Tyne Infirmary, on Thursday, April 8th, 1880, the President (Dr. Armstrong) in the chair.

The following gentleman was elected a member of the Society :—

John Service, L.R.C.S. and P. (Edin.), West Boldon.

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## PREVALENT DISEASES OF THE DISTRICT.

Mr. HENRY E. ARMSTRONG presented the following

*Return of Admissions to the Newcastle Fever Hospital during the month of March, 1880 :—*

	Case.	Dead.
Enteric Fever     ...     ...     ...	1	0

Dr. MACLAGAN said there had lately been an epidemic of pertussis in the villages of Prudhoe and West Wylam, and a case of small-pox at Whittonstall, besides a few cases of scarlatina, so-called, about the district.

Dr. REID said that in Newbiggen and district measles had been prevalent.

The PRESIDENT alluded to an unusual case which had come under his notice recently. A delicate young woman had fractured a rib from coughing. He thought the accident was sufficiently uncommon to justify him in bringing the case before the notice of the Society.

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## PATHOLOGICAL TRAY.

Dr. MURPHY exhibited specimens showing the results, after recovery from ovariectomy, of the extra and intra-peritoneal methods of securing the pedicle, and said : I have here, sir, the uterus, with the stumps of the pedicles, which I removed *post-mortem* from the body of a woman on whom I performed double ovariectomy some time ago, and who afterwards enjoyed a year's very good health, and then rapidly succumbed to malignant disease of the colon and

rectum. At the time the operation was done, August, 1878, I was rather in favour of the extra-peritoneal method of securing the pedicle, and accordingly one pedicle was treated with a clamp, and the other, which was short, was transfixed with a double carbolised silk ligature, the ends of which were cut short, and dropped into the abdomen with the stump. In the specimen before you the pedicle that has been treated with a ligature has near its extremity a furrow completely round it, marking the position of the ligature, but the vitality of the stump has continued beyond this furrow, and not a vestige of the ligature is to be found. From the time I let this stump fall back into the abdomen it gave me no annoyance or cause for anxiety; not so with the other, however. It first caused a good deal of discomfort to the patient by dragging; secondly, it prevented the edges of the wound from being brought completely together, which was to be desired, as drainage was uncalled for; thirdly, long after the remainder of the wound was completely healed it continued to discharge; and, finally, a portion of it disappeared altogether into the abdomen, and what remained, as you now see, is attached to the abdominal wall, and thus leaves an aperture into which a portion of intestine might readily pass and get strangled, which has actually happened in several recorded cases. When to the above I add that by the extra-peritoneal method the cicatrix in the abdominal wall is not rendered so strong as when the wound can be completely closed, thus exposing the patient to liability to hernia. I think, sir, you will agree with me that, as far as this case goes, the intra-peritoneal method was much the more satisfactory. I will not now enter into the general question of its advantages in all cases, but may quote the following from some correspondence I have recently had with Mr. Spencer Wells, where he states, "I have scarcely ever used the clamp since January, 1878, when I began to use antiseptic spray, &c. Since then I have almost always treated the pedicle on the intra-peritoneal principle by ligature. I use pure silk, carbolised, and since adopting the Listerian details of antiseptic treatment I have had a much greater success, and recoveries with far less fever." I may further add that the silk had better be steeped in the carbolic acid solution shortly before the operation, as if it has been kept some months or even weeks after having been carbolised, it becomes deteriorated, and readily snaps. Catgut is utterly unsuitable from its tendency to stretch and liability to slip. And as regards the objections (*a*) that the ligature is a foreign body in the peritoneal cavity, and by producing an exudation predisposes to peritonitis, the silk becomes absorbed, and that withdrawn produces peritonitis; and as to the assertion (*b*) that the ligature causes the pedicle to slough off in the peritoneal cavity, where it is absorbed

as putrid matter, I here show you that the vitality of the pedicle continues beyond where the ligature lies.

The PRESIDENT said that from the specimens which Dr. Murphy had just exhibited to the Society it would appear that the short pedicle was preferable.

Dr. GIBSON asked if there was any other malignant disease in the body?

Dr. MURPHY said that the rest of the body was free from the disease.

Dr. PAGE showed a splint invented by a Newcastle student, and said: This splint for the treatment of oblique fracture of the leg has been devised by Mr. Richard Fall, a student of this school. It consists of a back splint with a foot piece, and of two side splints. The ingenious contrivance by which extension is made, is the modification Mr. Fall claims to have introduced. An iron rod runs horizontally across the foot piece, the ends of which passing through holes in the side splint fixes them to the foot piece. The opposite ends of the side splints are similarly fixed by an iron rod, so that you have two opposite fixed points between which is the fracture. Extension is made by means of a screw attached to the upper rod, and connected with plasters adhering to the sides of the leg. The patient lies on his back. The leg is bent almost to a right angle with the thigh, secured to the back splint, and slung. The plasters are applied to cut from a stirrup which is connected with the screw above the knee. Extension is kept up by turning the screw. The splint obviates the tendency to displacement so often met with in treating oblique fractures of the leg, owing to movement of the pelvis when a back splint is employed; and Mr. Fall tells me he has used the apparatus with satisfactory results in the Ingham Infirmary, when he held the appointment of assistant to the house surgeon.

The PRESIDENT congratulated Mr. Fall, and said he thought the splint would be of service in cases of oblique fracture low down.

Dr. ARNISON said he thought the splint might be used for fracture high up, just below the tuberosity of the tibia.

Dr. DENHAM said that he could not see that the splint possessed much advantage over the usual long splint.

Dr. ARNISON showed—1. A disorganised knee joint from an adult. A large abscess had formed in the calf, and a smaller one in front of the joint, both being connected with the joint cavity. Amputation was necessitated by the patient's health giving way. 2. A leg amputated for cancerous ulcer on the outer side of the knee. The patient had been under Dr. Arnison's care in the

Infirmery a few months previously, and was then advised to submit to amputation, but refused. He placed himself under the care of a quack, who applied carrot poultices. No improvement following, he placed himself under the care of another quack, who applied some caustic; but as he found the case growing worse, he came into the Infirmary again, prepared to lose his leg. Both cases had done well.

Dr. Philipson being unable to attend the meeting, requested the Secretary (Dr. Drummond) to present to the Society the specimens down opposite his (Dr. Philipson's) name, viz., scrofulous kidney with fatty liver and gangrenous intestines.

Dr. BRAMWELL said he thought he had not seen such a fine specimen of a scrofulous kidney before.

Dr. DRUMMOND showed some microscopical slides (Histology) with the Sciopticon, and said it was through the kindness of Professor Marreco he was enabled to exhibit the apparatus to the Society. It was to be regretted that Mr. Marreco—who could have shown the slides with much better effect—had been unfortunately prevented from being present. The apparatus, as it stood, had been modified and much improved by Mr. Marreco. It could be utilised, and indeed had been used, for class purposes; the image being thrown on a screen just as in the case of the ordinary “magic lantern.” Unfortunately it was necessary to darken the room, a feature which militated against its usefulness when a large class of young students was the audience.

Mr. H. E. ARMSTRONG said he had known the apparatus for some time, and he had been much interested in it, as it occurred to him that many of the courses of lectures might be illustrated by its means.

Dr. BRAMWELL said he thought the necessity for darkening the room certainly would be against the general use of the Sciopticon in the lecture room; however, he thought the apparatus would be very useful as an aid in drawing diagrams. The diagram could be traced from the enlarged image on the screen.

Dr. DRUMMOND, in reply, pointed out that unless the lime light was used it was impossible to work with a high power, as clearness of definition could not be attained.

Dr. NEWCOMBE showed a new orum scoop, an instrument which he had devised to assist in the treatment of abortion, and said: Cases of abortion so frequently come into the hands of obstetricians, and are so often the cause of future trouble and disease, that I think any addition to their mode of treatment may be welcome. The great danger in connection with these cases is, that the complete evacuation of the uterus is sometimes difficult,

or even impossible, with the ordinary means at command ; and as no instrument I have seen has been devised that can safely, and painlessly, be introduced into the uterus, to draw away the placenta, pieces of membrane, or clots that may remain, I desired Messrs. Weiss, of London, to make from my design a uterine scoop, which I think answers the purpose. It consists of an instrument clearly shown by the engraving, made and jointed precisely the same as a pair of scissors, except that the join ends are round, and are covered with a soft elastic membrane forming a mouth-piece. It is ten inches long.

Fig. 1 shows the mouth-piece extended ; Fig. 2 shows it closed. It is slightly curved on the flat.

In a large number of cases the uterus contracts and expels the placenta, or it can be removed by the finger without trouble, and all goes well ; but in other cases, you have a large uterus, the cervix long and thickened, no appreciable thinning having taken place, the foetus having been forced through without any continued pressure on the internal os, and the cervix contracting on the placenta, leaving nothing but a thin soft friable cord to assist in its removal, the slightest traction being enough to tear it off, and leave one without a guide.

There may be a difficulty in introducing two or even one finger through the cervix, or you only get part of the placenta away ; or, after trying for some time, and causing the patient great pain, it is probably left to nature, with the result of an attack of septicaemia, metritis, abscess, or hæmatocele supervening, ending in chronic enlargement, frequent menorrhazias, a soft flabby condition of the uterus, and flexion, requiring the subsequent wearing of a pessary.

Now, what is the rational treatment in this state of affairs ? If the os uteri and cervix is so contracted that the placenta cannot be expelled, it may be necessary to dilute immediately with tents ; this takes time, and is a source of annoyance to the patient ; but, by means of my instrument, I contend that the contents can be evacuated with perfect safety. When closed, it can be flushed easily into the womb, taking no more room than a finger ; and, when opened, forms a small flat surface, which, like a hand, sweeps round the cavity, and having caught the contents, squeezes them out, a finger of the left hand assisting to guide the instrument.

After all abortions, I think a dose of ergot should be administered immediately to contract the womb, and three or four days after, it should be repeated at bedtime for two or three nights.

It is always wise to allow three or four days to elapse before beginning the specific ergot treatment, because I think I have seen an embolism result, on account of unequal contractions taking place from its too energetic administration before a certain amount of discharge, and absorption of tissue has taken place.

No woman is safe from the evil consequences of abortion, if the womb has not resumed its natural size and weight.

I am constantly called to see women suffering from repeated attacks of hæmorrhagia, dating from a miscarriage. The womb may have been thoroughly emptied, but a soft spongy condition has remained for months afterwards, and the fundus being large and heavy, is nearly always retroflexed, and unless this strangulated condition is recognised and reduced, the woman will remain a victim to chronic and ever increasing disease of the womb. All this might be prevented by the timely administration of ergot, and rest.

In addition to its legitimate use, I found my instrument very convenient last week in an obstetric case to which I was called, in which the cord was prolapsed, and I was enabled by its means successfully to push the cord back over the head of the child; so that, in more ways than one, I hope it may prove a useful addition to our obstetric use.

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#### DISCUSSION ON DR. MURPHY'S PAPER ON PUERPERAL ECLAMPSIA.

Mr. HAWTHORN said he had moved the adjournment at last meeting, as the hour was late, and the subject of Dr. Murphy's paper an important one. In 2,500 cases of midwifery, he had met with 15 cases of puerperal convulsions. Two of the cases died from pneumonia. The treatment he had adopted was chloroform, and delivery as rapidly as possible.

Dr. GIBSON remarked that Dr. Murphy's paper was certainly characterised by novelty. It, however, only dealt with eclampsia as a symptom of albuminuria, and proposed one mode of treatment for its cure, viz., transfusion of blood. This mode of treatment, again, was founded upon one recorded case, wherein transfusion was fairly indicated by anæmia and general prostration. Dr. Gibson questioned whether eclampsia ever could be contemplated as a symptom of albuminuria; and submitted that cases of puerperal eclampsia, with albuminuria, wherein plethora of the whole vascular system had preceded and accompanied the convulsions were very frequently observed, but in which the rational employment of transfusion of blood was a simple impossibility.

The PRESIDENT said he had not seen very many cases of puerperal convulsions; but in those he had seen he had noticed in some a plethora, and in others an anæmic condition; therefore, he did not think any one plan of treatment would be suitable for all cases.

Dr. MURPHY briefly replied.

## FACIAL DIPLEGIA.

By CHARLES GIBSON, M.D.,

LATE PHYSICIAN TO THE NEWCASTLE INFIRMARY.

BILATERAL paralysis of the muscles of the face has been observed on comparatively few occasions. Its phenomena are unaccountable; and the whole subject is surrounded with deep interest.

In this affection the whole of the muscles which are supplied by the facial nerves are commonly affected, and the affected muscles are palsied in a few, or many, or in all their fibres.

Although there may be a distinct relationship between bilateral and unilateral facial paralysis from time to time, there is a remarkable difference between the two affections, often, in their etiology; but especially in their manifestations; the twisted features and grotesque physiognomical expression of the latter, and the expressionless character of the former; wherein it is said that "the patient laughs and weeps as though behind a mask." The affection is sometimes associated with the glosso-labio-pharyngeal paralysis of Duchenne giving a still more remarkable physiognomy to the patient: the pouting lower lip, the cup-like reservoir between the lip and the gums, the accumulation here of saliva and its habit of overflowing; the difficulty of moving the tongue and lips accurately, and thus enhanced difficulty of speech; the imperfect action of the faucial muscles, and the consequent impairment of the function of deglutition; and with this the frequent escape of matters masticated, by the nostrils or mouth; and the tendency of foods and drinks to pass into the laryngeal chink, and provoke coughing and suffocative effects and vomiting. Then there is from time to time an interesting association of the affection, with loss of power in the extremities; most marked usually, but by no means confined to the lower limbs.

The following case affords a good illustration of the Facial Diplegia:—P. Q., æt. 32 years, a labourer, was admitted into the Newcastle Infirmary under my care. The man had not had any fit; but for five weeks prior to admission he had suffered from palsy of the lower limbs and a feeling of numbness and loss of power of the upper extremities. Sensation in the lower extremities was very slightly impaired. The tongue was protruded in a straight line. There was no paralysis of the bladder, or of the rectum. The countenance was remarkable; the cheeks were still and flaccid. The mouth was open from its relaxed sphincter; but there was little saliva flowing. Deglutition was apparently normal. Mastication was somewhat difficult, and food, both solid and fluid, became displaced in the mouth. There was almost no

control over the muscles of the cheek, nose, or ears. Faradaic electricity acted very imperfectly. Whistling and speech were performed badly. The conjunctivæ were congested; yet there was only trifling lachrymation; and the eyelids were only partially closed by voluntary effort or in instinctive resistance to irritation, applied to the conjunctivæ or to the edges of the eyelids. The eyes remained staringly open during sleep. Common sensation of the face was not perceptibly impaired. There was a general pallor of the countenance.

Two days after admission there was observed some volitional movement of the facial muscles.

Sixteen days after admission the patient could, with help, sustain the erect position of the body.

Twenty days after admission both eyes could be almost completely closed by voluntary effort, and irritations of the conjunctivæ were forcibly resisted. The angles of the mouth could be drawn up; and the act of whistling could be fairly well performed. The patient could now walk with help.

Thirty-one days after admission the patient was able to walk alone, and the muscles of the face appeared to have almost completely recovered their lost power.

On the forty-second day after admission the man was discharged from the hospital cured.

In the successful issue of this case doubtless the regulated diet and regimen of the hospital were very important factors. But the patient was further aided by certain medicinal agents: nitro-hydrochloric acid and purgatives, digitalis and iodide of potassium, strychnia with nitro-hydrochloric acid. Neither galvanism nor revulsives played any important part in the treatment.

What was the morbid anatomy—the proximate cause of this patient's palsy? Conditions extraneous to the cranium—not by any means uncommon in Bell's paralysis—might be operative here; such as direct application of cold, the presence of engorgement of blood vessels, &c. But these would not explain the special characters of the case, nor the simultaneous palsy of the limbs, nor the observed order of the process of restitution. Then conditions affecting the nerves in their course through the bony cranium might produce the diplegia; and Ehrmann reports a case wherein double otitis actually existed. These conditions can, however, rarely be present so as to effect double paralysis; and the same objections would hold here as held in the consideration of the operation of an extra-cranial etiology.

Again, the affection might depend upon some morbid condition of the cerebral hemispheres. Graves reports two cases from cerebral hæmorrhage, and the recent investigations of Ferrier and others certainly show that diseased conditions of the cortical

substance only of these hemispheres are competent to the production of paralyses which hitherto were supposed to be produced by centric disease elsewhere situated. In the case just reported there was, however, no lesion of the intelligence, nor of the organs of the special senses, and there was no vertigo. There was no intracranial pain, and it is probably a fact, as Erb asserts, that in facial paralysis of cerebral origin, the branches of the facial nerve which supply the orbicularis palpebrarum are not coincidentally affected consciously. Still it is almost incontestible that the lesion—the congestion, inflammation, effusion, softening, or tumour, &c., which was in operation in this case, was seated in the central nervous system; and I would submit that the relationship between double facial paralysis and so-called bulbar paralysis; the co-existence of the facial paralysis in this case with motor paralysis of the limbs, and the order of the progress towards restoration to health in the parts paralysed, all point to the immediate neighbourhood of the fourth ventricle as the seat of the lesion upon which depended the paralytic affection—the grey substance most probably about the site of the facial nuclei. In one example of the disease the affection was associated with disease of the Pons Varolii; and inasmuch as a decussation actually takes place in this region, it is fair to accept the conclusion that the seat of the causative intra-cranial disease may sometimes be here also.

Progressive bulbar paralysis commonly includes some manifestation in the direction of facial diplegia; yet it is remarkable that the facial nerves (so remarkably complex in constitution) may be profoundly affected without glosso-labio-pharyngeal palsy showing itself.





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